FACILITY FACTS RECORD

State Form 48160 (R3 / 7-06) / CM 0002

INSTRUCTIONS:
1) Complete form for each facility
2) Forward to address in upper right corner of form.

Indiana Family and Social Services Administration
Division of Mental Health and Addiction
Certification and Licensure
402 West Washington Street, Room W353
Indianapolis, IN 46204-2739

A facility is considered to be the point at which service is delivered. This form must be submitted when requesting renewal of certification/license; adding a service or facility setting; or discontinuing use of a facility location or a service offered at the facility. **One form must be completed for each facility location.** This blank form may be duplicated or computerized by the applicant to generate the required information in the same order as indicated below.
Please keep a copy of this form on file to report new services, new facility settings, discontinued use of a facility location, or discontinued service provided at a facility throughout the certification/license period.

1. General Information

Legal Name of Applicant Agency
(Check all that apply to this facility:) ☐ Operated by applicant agency ☐ New Setting or Service (**Effective Date:** _____) ☐ Discontinued Setting or Service (**Effective Date:** _____)
Name of facility
Location address of facility *(number and street)*
City, State, ZIP code, and County
Telephone Number

2. Array of Services

Applicants must indicate all services provided at this location. *(Check all that apply)*

☐ Individual Treatment Planning	☐ 24 Hour a Day Crisis Intervention	☐ Case Management
☐ Outpatient Services	☐ Acute Stabilization	☐ Residential Services
☐ Intensive Outpatient Services	☐ Detoxification Services	☐ Family Support Services
☐ Day Treatment	☐ Medication Evaluation and Monitoring	☐ Inpatient Care and Treatment

3. Fire, Health, and Safety Documentation

Documentation must be maintained by the applicant agency. Private Mental Health Institutions (Inpatient), Subactue settings, and Supervised Group Living Facilities must be inspected by the Office of the State Fire Marshal per request from the Division.

Fire and Safety Date of last fire/safety inspection	
Agency conducting fire/safety inspection	
Result: ☐ without violation	☐ with violation (Attach Plan of Correction)
Health and Sanitation Date of last health inspection	
Agency conducting health inspection	
Result: ☐ without violation	☐ with violation (Attach Plan of Correction)

4. Type of Service

Use 'X' or 'YES' to complete the three tables below. Indicate age, gender, population served, and beds at this location.

Table A. 24-Hour Care

Complete the table below.

An applicant must be a certified Residential Care Provider (or deemed Residential Care Provider) to operate a Supervised Group Living Facility, a Subacute Stabilization setting or Transitional Residential setting.

Use 'X' or 'YES' to complete the table below. Indicate age, gender, population served, and beds at this location.

Residential and Inpatient Care	Age 17 and under	Age 18 and over	Gender Male	Gender Female	Mentally Ill	Addictions	Compulsive Gambling	Detox	Total Beds in Facility
Transitional Residential Facility									
Supervised Group Living Facility									
Subacute Stabilization Facility									
Private Mental Health Institution – (Inpatient)									

Table B. Outpatient Treatment, Care, and Rehabilitation

Complete Table B below. Use 'X' or 'YES' to complete the table below. Indicate age and population served at this location.

Outpatient – Nonresidential	Age 17 and under	Age 18 and over	Mentally Ill	Addictions	Compulsive Gambling	Detox
Outpatient Treatment OR Intensive Outpatient						
Opioid Treatment						
Day Treatment/Partial Hospitalization						

5. Agency Identification

Printed Name of person completing the Facility Facts Record	Date *(month, day, year)*	Telephone Number
Email address of person completing the Facility Facts Record		
Applicant Agency		
Facility Location Address **(do not give Agency Address)**		